Meeting of the
Medicaid Revitalization Committee
August 29, 2006

Members Present:
Leslie C. Ellwood, M.D., Medical Society of Virginia /Virginia Academy of Pediatrics
Rose Chu, Board of Medical Assistance (on conference call)
Doug Gray, Medicaid MCO Representative
Mary Ann Bergeron, Virginia Association of Community Service Boards
Sheryl Garland, Virginia Commonwealth University
Marcia Tetterton, Virginia Association of Homecare
Judith Cash, Virginia Healthcare Foundation
Maureen Hollowell, Persons with Disabilities (on conference call)
Jill Hanken, Virginia Poverty Law Center (on conference call)
Alexander Macaulay, National Alliance on Mental Illness
Hobart Harvey, Virginia Health Care Association
Chris Bailey, Virginia Hospital and Healthcare Association
Diana Wallace, Virginia Association of Area Agencies on Aging
Timothy Musselman, Virginia Pharmacists Association

DMAS Staff:
Patrick Finnerty, Agency Director
Cynthia B. Jones, Chief Deputy Director
Cheryl Roberts, Deputy Director of Programs & Operations
Steve Ford, Director, Policy & Research Division
Gerald Craver, Policy Analyst, Policy & Research Division
John Kenyon, Policy Analyst, Policy & Research Division
Scott Cannady, Policy Analyst, Policy & Research Division

Meeting Facilitator:
Barbara Hulburt

Welcome and Overview of Agenda by Pat Finnerty, Director of DMAS

Mr. Finnerty began by welcoming everyone to the Medicaid Revitalization Committee (MRC) meeting. After his welcoming remarks, Mr. Finnerty reviewed the agenda. He indicated that the members would hear presentations from staff of the Department of Medical Assistance Services (DMAS) on the following topics: Medicaid managed care, employer-sponsored health insurance, Deficit Reduction Act (DRA) benchmark benefit flexibility options, and DRA cost-sharing provisions. Mr. Finnerty also informed the members that DMAS staff had prepared discussion points for the managed care and employer-sponsored health insurance presentations that they could consider as potential recommendations to the General Assembly. Mr. Finnerty emphasized that the discussion points were offered only to further the Committee's deliberations, and were not intended to limit discussion of other recommendations that the members may wish to make to the General Assembly. Mr. Finnerty concluded by informing the members that the meeting was scheduled to last from 9:00 am until 3:00 pm due to the amount of information that would be presented to the Committee.

All documents (including staff presentations) that were provided to the Committee members during the meeting are available on the Medicaid Revitalization Committee's website at: http://www.dmas.virginia.gov/ab-revitalization_home.htm.

Approval of the August 9th Meeting Minutes

The minutes of the August 9th MRC meeting were approved by the Committee members as written.

Presentation by Cheryl Roberts, DMAS Deputy Director of Programs and Operations, on Managed Care

The presentation by Ms. Roberts provided the Committee members with an overview of Virginia's Medicaid managed care program. She informed the committee that 36 states have contracted with MCOs to provide services to Medicaid recipients. Ms. Roberts said that all of the state managed care programs operate differently because there is no standard MCO model. For instance, some states require mandatory MCO enrollment, while other states allow voluntary enrollment. Moreover, some states use a full risk MCO payment model, while others use a non-risk payment model. Ms. Roberts pointed out that Virginia gives its seven MCOs considerable flexibility in designing programs because they are required to assume full risk for providing services to Medicaid recipients. She also said that Virginia's MCO model requires that at least two plans be available in each locality to provide services to recipients. Ms. Roberts reported that the MCO program has been very successful in terms of providing quality services and that the state has good working relationships with all MCOs. She also reported that the MCOs operate in 110 Virginia localities, but that the state is planning to expand the program into additional localities due to its success. Consideration is also being given to including additional eligibility groups within the managed care program (Virginia currently requires recipients in the following eligibility groups to enroll in managed care: FAMIS, families and children, disabled, and medically indigent). Ms. Roberts also indicated that the program is experiencing some difficulty in expanding and in maintaining coverage in certain areas due to network development issues related primarily to reimbursement rates.

After Ms. Roberts' presentation, Mr. Finnerty reviewed the three discussion points that were developed by DMAS staff to guide the Committee's deliberations. The discussion points are summarized below.

Discussion Point #1 (side 30)

The first discussion point asked the Committee to consider whether or not DMAS should continue working toward expanding the MCO program into new regions of the state and across additional eligibility groups. The discussion point also asked the MRC to determine if DMAS should continue to use a risk-adjustment methodology in setting capitation rates for contracted MCOs.

Discussion Point #2 (slide 31)

The second discussion point asked the Committee to consider whether or not DMAS should seek federal approval and funding to modify and expand the MCO program using a defined contribution approach. The discussion point also asked the MRC to determine if Medicaid premiums should be established through a risk-adjusted methodology and if the MCOs should have the ability to offer additional benefits to recipients.

Discussion Point #3 (slide 32)

The last discussion point asked the Committee to determine whether or not DMAS should seek federal approval to modify the fee-for-service and MCO programs to include a monetarily defined benefit cap that, once reached, would terminate recipients' Medicaid expenditures for healthcare services.

After presenting the discussion point options, Mr. Finnerty turned the facilitation of the meeting over to Barbara Hulburt. Highlights of the committee's deliberations include the following:

- Care should be taken when expanding the MCO program to ensure that vulnerable populations (i.e., Medicaid Part C children and adults with mental illness) continue to receive appropriate healthcare services. Concerns were raised that mentally ill recipients who are in the fee-for-service Medicaid program may not receive appropriate care through the MCOs because the plans are only covering selected services for this population.

- Concern was expressed over whether the MCOs will establish appropriate rates for physicians and other healthcare providers in the expansion areas of the state. Some members pointed out that it may not be economically viable for the MCOs to expand into certain rural areas due to low numbers of providers. Some members suggested that DMAS intervene in the rate negotiations between the MCOs and the providers; however, most members indicated that full risk-bearing plans should have the ability to negotiate rates with providers.

- Alternative approaches (i.e., contract with federally qualified health centers or use telemedicine to provide services) should be considered for providing managed care services in rural areas of the state.

- Additional Medicaid eligibility populations should be included in managed care such as foster children and long term care recipients. It was indicated by some members that these recipients could receive better healthcare services through managed care than through the traditional fee-for-service program.

- Many committee members did not support implementing a market-driven defined contribution benefit approach in the Medicaid program. However, some members indicated that this approach might be feasible for certain Medicaid populations. As a result, it was suggested that the state explore this benefit option through a "request for information" proposal to determine if the MCOs are interested in offering the benefit to their Medicaid clients. One member stated that stakeholders must understand that the defined contribution benefit approach represents a fundamental change in the Medicaid program because it will limit recipients' access to benefits.

- The Committee unanimously declined to move forward on discussion point #3 because of the limitations that would be imposed on recipients' healthcare services if the State established a benefit cap in the Medicaid program.

After comments and suggestions were provided by the committee members, Ms. Hulburt summarized the committee's consensus on the discussion points as follows:

1. **DMAS should move forward with expanding the current risk-bearing MCO model in the remaining areas of the state where feasible and explore other options for expanding managed care where the state's current model is not feasible.**

2. **Attention should be given to ensuring that all Medicaid recipients have access to care during the MCO expansion with particular emphasis on vulnerable populations.**

3. **Additional Medicaid eligibility populations (such as foster care children and the elderly) should be included within the managed care program.**

4. **DMAS should not modify the Medicaid program to include monetarily defined benefit cap(s) that would terminate Medicaid expenditures for healthcare services on behalf of eligible recipients.**

Presentation by Pat Finnerty, Director of DMAS, on Employer Sponsored Insurance Options and "Buy-In" Programs

Mr. Finnerty's presentation provided the Committee members with information on employer-sponsored health insurance options and "buy-in" programs. Mr. Finnerty informed the Committee members that HB 758 directs the MRC to examine the option of allowing Medicaid recipients to purchase employer-sponsored health insurance. Mr. Finnerty reported that DMAS will pay for Medicaid enrollees to purchase insurance through their employers if the agency determines that such coverage is more cost-effective than Medicaid coverage. He also reported that Virginia already has three programs (Health Insurance Premium Payment Program, FAMIS Select, and Medicare Premium Assistance "Buy-In") that provide assistance to recipients who wish to purchase non-Medicaid health insurance. He indicated that Virginia is implementing, or considering implementing, buy-in options for its Medicaid and FAMIS programs to allow certain enrollee groups to pay to participate in these public programs. Mr. Finnerty noted during the

presentation that DMAS already subsidizes Medicare cost sharing for dual eligible beneficiaries. He also reported that the 2006 General Assembly directed the agency to establish a Medicaid Buy-In program to allow certain working people with disabilities to pay a premium to participate in the Medicaid program, and that the legislature directed the agency to study the feasibility of implementing an SCHIP buy-in program. Finally, Mr. Finnerty reported that DMAS is considering implementing a Deficit Reduction Act optional provision, called the Family Opportunity Act, as an additional buy-in option within the state Medicaid program.

After the presentation, Mr. Finnerty reviewed the discussion point that DMAS staff developed to guide the Committee's deliberations on the employer sponsored health insurance and buy-in programs. The discussion point is summarized below.

Discussion Point #4 (side 56)

The discussion point asked the committee to determine if DMAS should continue to expand programs that subsidize employer sponsored/private health insurance. The discussion point also asked the MRC to determine if these programs should be mandatory for certain Medicaid eligibility groups.

After reviewing the discussion point, Mr. Finnerty turned the meeting over to Barbara Hulburt. Highlights of the committee's deliberations on this issue included the following:

- Concern was expressed over the effect that an enhanced buy-in option may have on the state's Medicaid program because high-risk individuals will probably be more interested in this option than low-risk individuals.

- Concern was also expressed over how wrap-around coverage will be provided to Medicaid recipients who receive insurance coverage through their employers. Some members indicated that the state may wish to consider allowing cost sharing requirements to apply to recipients who participate in employer sponsored health insurance. Other members indicated that DMAS should review employer sponsored health insurance programs in other states (such as Florida) to determine if this program offers a viable alternative for addressing the wrap-around coverage issue.

- Considerable debate occurred over whether the state should require recipients to participate in employer sponsored health insurance programs. Some members indicated that DMAS should explore the feasibility of establishing a voluntary enrollment option into the state's Health Insurance Premium Payment Program (HIPP). Many members indicated that more information was needed on how voluntary HIPP enrollment would impact the wrap-around coverage benefit.

After the Committee members provided their comments and suggestions, Ms. Hulburt summarized the Committee's consensus on the discussion point as follows:

1. **DMAS should expand programs for public subsidy of employer-sponsored and/or private health insurance coverage for selected Medicaid recipients where such coverage is feasible and with attention paid to the concerns raised by the Committee.**

2. **The Committee needs more information on the "pros" and "cons" of mandatory versus voluntary enrollment into employer-sponsored and/or private health insurance coverage programs before an appropriate course of action can be decided upon.**

Presentation by Steve Ford, DMAS Policy Director, on Benchmark Flexibility and Cost Sharing/Premium Structure Provisions of the Deficit Reduction Act.

The presentation by Steve Ford provided the Committee members with information on the benchmark flexibility and cost sharing/premium structure provisions of the Deficit Reduction Act (DRA). Mr. Ford reported that HB 758 did not require the MRC to consider these provisions. However, he informed the Committee that DMAS provided this information because the agency wanted to solicit advice from the MRC on how to proceed with these provisions. Discussion points for these topics were not developed because they were not included in HB 758. The presentation by Mr. Ford is available on the MRC's website.

Mr. Ford reported that the DRA allows states, through the state plan amendment process, to alter benefits to Medicaid recipients as long as the revised benefit packages meet or exceed benefits in certain benchmark plans such as the Blue Cross/Blue Shield PPO or state employee health plans. Mr. Ford also reported that the DRA provides states with flexibility in the establishment of cost-sharing requirements for certain non-exempt Medicaid recipients. In particular, the DRA allows cost sharing up to 10 percent of the cost of the service for recipients with family incomes from 100 percent to 150 percent of the federal poverty level (FPL). For recipients with family income greater than 150 percent FPL, the DRA allows cost sharing up to 20 percent of the cost of services. In addition, Mr. Ford reported that the DRA allows "special" cost sharing for prescription drugs up to 20 percent of the cost of the drugs for recipients with incomes greater than 150 percent FPL. The DRA also allows cost sharing for non-emergent use of hospital emergency rooms. Mr. Ford informed the committee that the Virginia Medicaid program currently has cost sharing provisions. For example, the Medicaid program charges a $1 co-pay for generic drugs and a $3 co-pay for brand name drugs. Mr. Ford further reported that DMAS discourages the inappropriate use of emergency rooms through reduced payment to providers and through management of care in the Medallion II and MEDALLION PCCM programs.

After the presentation, the meeting was turned over to Barbara Hulburt. Highlights of the committee's deliberations on this issue included the following:

- If the state develops benchmarking plans, then recipients should have the flexibility to move between the plans as their health care needs change. However, consideration should be given to determining which populations will be subject to the benchmark plans because not all recipients are capable of making rational decisions.

- Benchmark plans should include both "carrots" (i.e., assistance in paying for services that are currently unavailable) and "sticks" (i.e., denying services) to prompt recipients to become more engaged in managing their own health care needs. However, the benchmark plans should include more carrots than sticks. In addition, the burden of enforcing the benchmark plans will primarily fall on the providers because they will have to inform recipients (who fail to comply with their care plans) that they cannot receive certain services.

- Cost sharing requirements may not be feasible for some Medicaid populations because they may not be able to afford the co-payments. Cost sharing requirements can place burdens on physicians and other health care providers because it can be expensive for them to collect co-payments and it puts them in the position of having to deny needed services if the recipients are unable to pay the co-payments.

After the Committee members provided their comments and suggestions, Ms. Hulburt summarized the Committee's consensus on the discussion point as follows:

1. **The benchmark and cost sharing provisions should be incorporated into the recommendations that have already been made by the Committee.**

2. **The committee's final report should inform the General Assembly that Virginia already performs many of the provisions included in HB 758.**

After the committee concluded its discussion, Mr. Finnerty informed the members that the next MRC meeting is scheduled for September 21, 2006 from 9:00 am to 12:00 pm. He also announced that DMAS staff will present a draft of the final report for the committee's review during the meeting. In addition, he informed the committee that members of the public will be allowed to speak during the meeting. Following Mr. Finnerty's announcements, Ms. Hulburt adjourned the meeting at approximately 3:00 pm.